The Commonwealth of Massachusetts
Department of Public Health
Division of Health Professions Licensure
Board of Registration of Nursing Home Administrators
239 Causeway Street
Boston, MA 02114
www.mass.gov/dph/boards
617-727- 4499

INSTRUCTIONS FOR RECIPROCITY APPLICATION

1. All application materials, including forms that are filled out by other individuals and official transcripts, must be submitted at the same time in a large envelope.

2. Provide a self-addressed envelope to your endorsers with your Reference Forms, Physician Form and Transcript(s). After the individual has completed the form or placed an official seal on your transcript, he/she must seal it in the return envelope you provide, sign his/her name across the envelope seal, and return it to you.

3. Reciprocity candidates must submit the following materials and information:
   a. A current resume that describes your long term care facility experience.
   b. A copy of a current valid Nursing Home Administrators license from the state in which you are practicing. The copy must provide the license number and expiration date.
   c. State Verification Form from the state in which you are currently practicing in a signed, sealed envelope.
   d. Official transcript[s] in signed sealed envelope[s].
   e. A report of your scores on the National Exam or state exam which you may obtain from the state that administered the examination or through: **Interstate Reporting Service, 111 Eight Avenue, Room 526, New York, NY 10011, telephone number (212) 367-4338 (must be in a signed, sealed envelope).**
   f. Four Completed Reference Forms in signed, sealed envelopes:
      3 professional;
      1 personal.
   g. Completed Physician Form in a signed, sealed envelope.

4. If an applicant for reciprocity holds a current valid license as a nursing home administrator in another state and also holds current certification as a nursing home administrator from the American College of Healthcare Administrators please submit the following documents in lieu of the materials listed in #3 above:
   a. A copy of a current valid Nursing Home Administrators license from the state in which you are practicing. The copy must provide the license number and expiration date.
   b. Verification from the state you are currently practicing in that your license is in good standing in a signed, sealed envelope.
   c. Authenticated verification from the American College of Healthcare Administrators of current certification in a signed, sealed envelope.

5. Please retain a copy of the complete application package for your records.

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RECIPROCITY APPLICATION CHECKLIST

The following must be included for a complete application.

_____ Reciprocity Application Form *

_____ Resume *

_____ Fee $100.00 check or money payable to Commonwealth of Massachusetts NH *

_____ Photograph 2” x 2” *

_____ Official transcript(s) in signed, sealed envelopes

_____ Four Reference Forms in signed, sealed envelopes
3 professional
1 personal

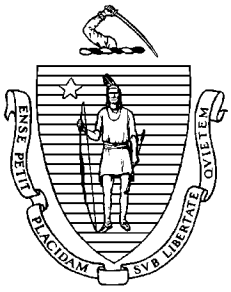
_____ Physician Form in a signed, sealed envelope

_____ State Verification Form in a signed, sealed envelope *

_____ Score reports for either the national exam or state exam in a signed, sealed envelope

_____ Copy of current valid nursing home administrators license *

* For applicants with current certification from the American College of Healthcare Administrators submit the items * above and an authenticated verification of ACHA certification.



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RECIPROCITY LICENSE APPLICATION

[READ INSTRUCTIONS, THEN PRINT OR TYPE]

1. Applicant Name: _____
Last First Middle

Maiden Name/Other Name: _____

2. Permanent Address: _____
No. Street Apt. #

_____
City/Town State Zip Code

3. Business Address (If Applicable): _____
No. Street Suite #

_____
City/Town State Zip Code

4. Which address should appear on your license? Permanent ☐ Business ☐

5. Date of Birth: _____ 6. E-mail: _____

7. Telephone Number-Day: _____ Evening: _____

8. Social Security Number **(Mandatory)**: _____

Pursuant to M.G.L. c. 62C, s. 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

9. Educational Background:

Highest Degree: _____ Year: _____
Academic Major: _____
School Name: _____
School Location: _____

10. Professional Experience:

Number of Years of Long Term Care Experience: _____
Length of Administrator-in-Training program: _____
Date of National Examination (approximate): _____
Number of Years of Administrator Experience: _____

Board of Registration of Nursing Home Administrators

Applicant Name_____

11. List all professional licenses/certifications you have held in the United States, or any country or foreign jurisdiction, and the state/jurisdiction from which the license/certification was originally issued. Enclose a certificate of standing from each state or jurisdiction in which you have been licensed/certified, indicating the status of your license and any disciplinary information in a sealed envelope from the entity. (use a separate sheet if necessary):_____
_____
_____

12. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____
_____
_____

13. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____
_____
_____

14. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____
_____
_____

15. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____
_____
_____

16. Have you ever been convicted of, or admitted to, a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $200.00 was assessed? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____
_____
_____
_____

Board of Registration of Nursing Home Administrators

Applicant Name_____

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Nursing Home Administrators to deny me a license or to suspend or revoke a license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to M.G.L. c. 62C, s. 49A, to the best of my knowledge and belief, I have filed all Massachusetts tax returns and paid all Massachusetts taxes required by law.

I further certify that I have continued to maintain my professional competence through formal study and that, if requested, I can provide documentation to the Board.

_____ _____

Signature of Applicant Date

Recent 2x2
Passport style
Photo

Notary Name (print) _____

Notary Signature _____

Commission expires_____

[Seal]

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STATE VERIFICATION FORM
RECIPROCITY LICENSURE REQUEST

_____ has made application for reciprocal licensure in the
name
Commonwealth of Massachusetts. According to the information he or she has filed, the applicant states he or she is currently licensed in your state. Would you, therefore, please complete the following and return to the applicant in a signed, sealed envelope within ten (10) days.

APPLICANT NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ SOC. SEC. NO.: _____
Mandatory

LICENSE NO.: _____ DATE ISSUE: _____ EXP. DATE: _____

1. Is the above information the same as your records indicate? YES ____ NO _____
   If no, please explain: _____
   _____

2. Was your state the state of the applicant's original licensure? YES ____ NO _____
   If yes, give date: _____. If no, what do your records indicate as the state of original licensure? _____.

3. Did the applicant take a written examination for licensure? YES _____NO _____
   If yes, which examination(s): _____
   Exam Series No.: _____ Total Raw Score: _____
   Scale Score: _____

4. According to your records, is the applicant in good standing with your Board at this time?
   YES _____ NO _____ If no, please explain: _____
   _____

5. According to your records, has the applicant ever been disciplined by your Board or any other state agency? YES _____NO _____ If yes, please explain: _____
   _____

6. Was the applicant required to do an Administrator In Training program in your state?
   YES _____NO _____ If yes, was program completed? YES _____NO _____
   Length of AIT Practicum: _____
   _____

7. Has the applicant, according to your records ever been convicted of a felony?
   YES _____ NO _____ If yes, please explain: _____
   _____

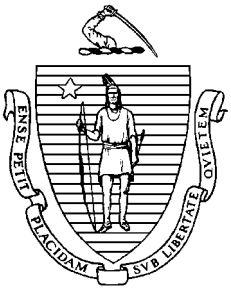
8. Please make any additional comments in the space provided: _____
   _____
   _____

The Board appreciates your cooperation in supplying the information requested. Once you have completed the form please, place it in the envelope provided and sign your name across the envelope seal. Then send it to the applicant.

Chairman or Designated Administrator: _____
signature

Date: _____ State: _____

Board seal:



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PHYSICIAN FORM

1. NAME OF APPLICANT: _____

2. NAME OF LICENSED PHYSICIAN: _____

3. ADDRESS OF PHYSICIAN: _____
   No. Street Apt. #

   _____
   City/Town State Zip Code

4. PHYSICIAN STATE LICENSE NUMBER: _____
   Number Expiration Date

I hereby certify that the above named applicant is in good health and has no mental or physical impairment that would prevent him or her from discharging the responsibilities of a Nursing Home Administrator.

_____ _____
Physician Signature Date

Once you have completed this form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.

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REFERENCE FORM

You have been requested to provide reference information for _____, an applicant for registration as a Nursing Home Administrator in Massachusetts under the provisions of Section 74, Chapter 13 of the General Laws of this Commonwealth. Pertinent information concerning the applicant will be helpful to the Massachusetts Board of Registration of Nursing Home Administrators.

In order that the provisions of the licensing law may be effective in safeguarding public health, safety and welfare, the Board of Registration of Nursing Home Administrators has been charged with the responsibility of limiting the use of the title "Nursing Home Administrator" only to those who are found qualified and suitable for that profession. As one of the applicant's references, you are familiar with his/her professional work or have knowledge of his/her ability, character and reputation. The Board would appreciate information which bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence and character.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please place it in the envelope provided and sign your name across the envelope seal. Then return it to the applicant.

MASSACHUSETTS BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS

REFERENCE FORM

Please type or print clearly:

1. NAME OF APPLICANT _____

2. PROFESSIONAL, OR OTHER RELATIONSHIP TO APPLICANT _____

3. NUMBER OF YEARS YOU HAVE KNOWN APPLICANT _____

4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE PERSONAL KNOWLEDGE:
   a. Professional knowledge and experience: _____
   b. Character with respect to honesty, integrity, and general conduct: _____

5. DO YOU RECOMMEND THE APPLICANT FOR REGISTRATION AS A NURSING HOME ADMINISTRATOR: YES _____ NO _____ If no, please attach a detailed written explanation of your reasons for not recommending this applicant.

6. OTHER COMMENTS: _____

(Attach an additional sheet of paper, if you wish to make additional comments)

I hereby certify that the information given above is correct to the best of my knowledge and belief, and opinions expressed above represent my best judgment. I hereby agree to provide further information to the Board if requested to do so.

Name (type or print clearly)		Signature
Business Address		Date
City and State	Zip Code	Occupation
Home Address	City, State	Zip Code